Statewide Coordinated Statement of Need for Persons Living with HIV and AIDS In Idaho

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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Southeastern Idaho AIDS Coalition
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Introduction

Idaho's Statewide Coordinated Statement of Need (SCSN) is an outline of the needs, the services available and gaps in the services available for individuals living with HIV or AIDS in the State of Idaho. The SCSN was developed by individuals living with HIV and AIDS, Ryan White CARE Act grantees, Title II Consortia members, care providers, the Idaho Care Prevention Council, and the STD/AIDS Program. Also identified are the epidemiological trends as well as the unmet needs and barriers to accessing care for individuals who are living with HIV or AIDS in the State of Idaho. The SCSN promotes a shared vision for effective planning and coordination of care services across the state by prioritizing needs.

Purpose

The purpose of the SCSN is to identify current and future needs of individuals living with HIV or AIDS residing in the state of Idaho, providing a document for which Ryan White CARE Act grant recipients, providers, and other community members could utilize to develop policy, procedures, and delivery of services. It is the goal of this document to maximize CARE Act program coordination within the state, working towards 100% access to and 0% disparity in the provision of HIV -related services.

Goals

Increase the accessibility and availability of health care services for persons at all stages of HIV infection, including those at risk.

Increase the availability and effectiveness of support services for all individuals, families, and communities struggling with HIV/AIDS.

Monitor quality assurance of Ryan White Title II HIV/AIDS case management services.

HIV/AIDS Programs Administered By the Idaho STD/AIDS Program

The Idaho STD/AIDS Program administers a Ryan White CARE Act Title II, grant and receives HIV/AIDS Prevention funds through the Centers for Disease Control. The state of Idaho also receives Ryan White CARE Act Title III, funding a primary health care clinic located in Boise, Idaho, a satellite clinic in Pocatello, Idaho, and a physician who travels to south central Idaho. Northern Idaho residents have access to CHAS (Community Health Association of Spokane) which receives Title III funding located in Spokane, Washington. The STD/AIDS Program is the LPS (Local Performance Site) in Idaho for the NW AETC (Northwest AIDS Education and Training Center) and receives funding to provide HIV/AIDS education to primary care physicians, pharmacists, dentists, dental hygienists, nurses, nurse practitioners, and physician assistants throughout the state.

Title II HIV Care Act Grant

In 2002, Idaho received just over $900,000 in Title II funds. The grant supports two primary activities, the AIDS Drug Assistance Program (ADAP), and health care and support services for persons living HIV and AIDS.

ADAP (AIDS Drug Assistance Program), which accounts for 67.5 percent of Title II funds received, is administered directly by the Idaho STD/AIDS Program. Idaho's ADAP provides medication to low-income individuals living with HIV and AIDS, who are not Medicaid eligible and who have no private insurance covering medications. The current enrollment cap is limited to 92 eligible clients. As of October 2002, a waiting list has not existed for 10 months. The vast majority of ADAP clients are over 20 year of age, 83 percent of these persons are male; and 20 percent are minority.

ADAP has expanded it's formulary to cover 36 HIV/AIDS and OI (opportunistic infections) medications, including six protease inhibitors. ADAP also provides CD4 and viral load testing to eligible clients. The program is guided by an Idaho ADAP Advisory Committee, which recommends policies and procedures for adding drugs to the program, performs some program management and formulary reviews.

The State of Idaho receives $177,500 state dollars annually to supplement federal funding. This funding is based on the availability of state financial resources.

During FY2002, Title II funds for other HIV/AIDS care services were contracted to three regional HIV Care Consortia which serve five of Idaho's seven health districts:

- North Idaho AIDS Coalition (Districts 1 and 2)
- South Central Idaho AIDS Coalition (District 5)
- Southeast Idaho AIDS Coalition (Districts 6 and 7)

Funding is distributed to each consortia based on regional case load prevalence. Through Title II support, over 100 individual's statewide living with HIV and AIDS receive case management, medical, dental, transportation, psychosocial and other covered services.

Health Districts 3 and 4 are eligible to receive services from the Ryan White Clinic in Boise, Idaho. The Ryan White Clinic receives Title III funds and supports two full time case managers and a mental health counselor. The Ryan White Clinic in Boise also supports a satellite clinic providing HIV care to individuals living with HIV or AIDS in Southeastern Idaho.

HIV/AIDS Prevention Grant

The Idaho STD/AIDS Program receives federal HIV prevention funds. Allocation of the funds is guided by the Idaho Comprehensive HIV Prevention Plan. The Comprehensive HIV Prevention Plan is a product of the Idaho Care Prevention Council in accordance with CDC's community planning guidance. Prevention services conducted throughout the state include counseling, testing, referral and partner notification; health education/risk reduction; public information; capacity building; and provider training. Prevention activities are carried out by Idaho's seven district health departments and other private sector prevention partners, as well as part-time AIDS Advocates in each region to coordinate HIV prevention services and promote community networks. During the first six months of 2002, there were a total of 3,866 HIV tests processed through the state laboratory. The STD/AIDS Program also funds several peer education and support projects for gay men, women at risk, and injection drug users through community based organizations.

Summary of Idaho's HIV/AIDS Epidemiological Profile and HIV Prevention Plan

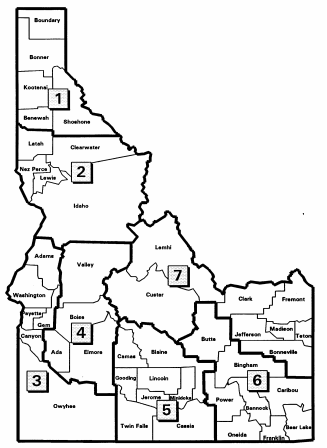
State Population

Based on the 2000 census, Idaho's population is 1,293,953, and was the nation's fifth fastest growing state. Idaho is one of the most rural states in the nation. Approximately 88% of Idaho's towns and cities have populations of less than 2,500. According to the Office of Management and Budget, only three counties (Ada, Canyon, and Bannock) are considered Metropolitan Statistical Areas, the other counties are non-MSA (rural). Thirty-four percent of Idaho's residents live in rural areas. The state's largest city, Boise has a population of approximately 185,787, and the next largest cities in Idaho are Nampa at 51,867 and Pocatello with 51,466.

Idaho's small, isolated population centers, separated by vast distances of mountain and desert terrain, pose a challenge to the provision of accessible disease prevention, health education, and health care services. With few metropolitan areas, many residents seek comprehensive services out-of-state. Northern Idaho residents typically travel to Spokane, Washington and persons in southeast Idaho utilize service in Salt Lake City, Utah.

Regional Population

Idaho is divided into seven public health districts. Each health district is an independent agency governed by a local board appointed by the county commissioners in that district. There are 32 branch/satellite health departments. The branch health departments are small compared to the district health departments and are located in the majority of the counties comprising the seven health districts. The public health districts work in cooperation with the Idaho Department of Health and Welfare's Division of Health to provide an array of contractual services. These services range from community health nursing and home health nursing to environmental health, reproductive health, dental hygiene and nutrition programs. All districts currently offer confidential HIV counseling, testing, partner notification, and referrals; however the districts do not provide specialty care for individuals living with HIV or AIDS. A map of the seven public health districts is included.



Each district health department contains four to eight counties and demographically contains one of the seven population centers of Idaho as well as frontier and rural counties. The 2000 census results are shown below:

District	2000 Population	% of Population
District 1	178,333	14%
District 2	100,533	8%
District 3	191,297	15%
District 4	344,355	27%
District 5	162,397	12%
District 6	156,905	12%
District 7	160,132	12%
TOTAL	1,293,953	100%

Race/Ethnicity

Historically, Idaho population by race has not been representative of the national racial population. In the 2000 census, Idaho's population consisted of 89% white (non-Hispanic), 0.4% black or African American (non-Hispanic), 1.0% American Indian and Alaska Native, 0.9% Asian, 0.1% Native Hawaiian and other Pacific Islander, 1.0% reporting two or more races, and 1.4% of individuals reporting some other race. Idaho's Hispanic population grew from 52,927 in 1990 to its current population of 101,690, 7.9% of the total population.

Migrant and seasonal farm workers are a significant part of Idaho's Hispanic population. A migrant farm worker is defined as a person who moves from outside or within the state to perform agricultural labor. A seasonal farm worker is defined as a person who has permanent housing in Idaho and lives and works in Idaho throughout the year. In 1989, when the Migrant Health Branch within the U. S. Department of Health and Human Services, conducted their last survey, it was estimated that over 119,900 migrant and seasonal farm workers and their families resided in

Idaho, at least temporarily.

Idaho is also home to six American Indian tribes: the Coeur d'Alene, Kootenai, Nez Perce, Northwest Band of the Shoshoni, Shoshone-Bannock, and Shoshone-Paiute. There are an estimated 17,645 American Indians living in the state.

Poverty

Based on the 2000 census, 13.0% of all Idaho residents have incomes below the poverty level. Idaho's per capita income for 1999 was $17,841, $3,746 below the national average. The state's unemployment rate in August of 2002 was 5.4%.

Medically Uninsured

In October 2001, the Idaho State Planning Grant, administered by the Idaho Department of Commerce, was one of twenty state planning grants funded in the past two years by the Health Resources and Services Administration, U. S. Department of Health and Human Services. The charge of the Grant was to identify and describe Idaho's uninsured, to evaluate a wide array of policy options and to develop a comprehensive plan for providing access to insurance for all Idahoans. The report describes the demographic and economic characteristics of the uninsured. While Idaho's rates of uninsured generally reflect the national average, they mask pockets of uninsured among Idahoans employed by small business, Idaho's Hispanic population and poor children. This is partially driven by a growing split in population between large population areas and rural and frontier areas. Nearly 80% of Idaho's uninsured are working families. Eighteen percent of the state's population is uninsured. The uninsured counties in Idaho currently have a rate from 15% to over 30%. It should be remembered, however, that in the case of some counties their rates may be high but the county population may be quite small. Forty-two percent of the uninsured live in rural or frontier counties. Thirteen counties represent 70% of the total number of uninsured. These counties are those that surround the state's larger population centers (Boise, Twin Falls, Pocatello, Idaho Falls, Moscow, and Coeur d'Alene).

System and Provider Capacity

System and provider capacity to deliver HIV services continues to be a challenge in Idaho. Capacity issues include: 1) Non HIV-specific health and human service providers often do not have the training or institutional capacity to deal with the special problems of the HIV positive client; 2)

primary care providers in Idaho lack information about the existence of HIV resources.

There is also a need to incorporate "best practices" based upon the experience of HIV providers throughout the state into standards of practice. Developing a formal mechanism to capture and share solutions developed through experience would be a benefit to the HIV service delivery system.

Collaboration between the STD/AIDS Program and the Ryan White Title III Clinic located in Boise would enable a coordination of services throughout the state. Using the Building Blocks model developed by the Regional Program on AIDS/STI of the Pan American Health Organization (PAHO), Regional Office of the World Health Organization, in collaboration with the World Health Organization (WHO) Headquarters, and the United Nations Joint Programme on HIV/AIDS Care (IAPAC) would provide a framework of HIV/AIDS comprehensive care.

Currently in Idaho there are 613 general/family practitioners, 130 pediatricians, 127 OB/GYN's, and 286 general internal medicine practitioners. However, only a small fraction of these practitioners provide HIV specialty care to individuals living with HIV or AIDS. Since the STD/AIDS Program receives funding from the NW AETC to provide up to date HIV/AIDS education to primary care physicians, the following mechanisms of training will be utilized.

- Primary care providers located in Idaho, both in urban and rural areas, will be contacted for the opportunity to participate in HIV education and training
- At each training site a training will be scheduled for a "HIV 101" and will possibly have a follow-up training on "HIV Pharmacological Update"
- Providers will also be supplied with resources and contact information on how to utilize the services available from the NW AETC (ex: clinical consultations, preceptorships, and future training opportunities)

Ryan White Title II funds have been used during FY 2002 to provide case management, medical care including necessary laboratory tests (i.e., CD4 and viral load), dental, mental health counseling, housing services, transportation, and nutritional services to approximately 206 individuals living with HIV or AIDS. Services utilized from January 1, 2002 through October 31, 2002 include:

CD4 count:	86 units/63 clients
Viral Load:	89 units/63 clients
Medical:	203 units/99 clients
Dental:	10 units/7 clients
Mental Health Counseling:	19 units/11 clients
Case management:	2649 units/206 clients
Housing:	2 units/2 clients
Transportation:	62 units/40 clients
Nutritional Services:	15 units/7 clients

Administrative rules are being promulgated to help guide the planning and disbursement of funds for the STD/AID Program Ryan White CARE Act Title II and the ADAP (AIDS Drug Assistance Program). These rules will also help to clarify current practices. The rules address eligibility for HIV related services, how participants apply for assistance, what services are available, how the funds for services are distributed, what medications are available to be paid for through the HIV/AIDS Drug Assistance Program (ADAP), and what happens if false information is given to the program. These proposed rules will go before the Idaho Legislature during the 2003 session beginning in January 2003.

HIV/AIDS

The epidemiologic profile is composed of information gathered to describe the effect of HIV/AIDS on Idaho in terms of sociodemographic, geographic, behavioral, and clinical characteristics of the general population, HIV -infected populations, and persons whose behavior places them at risk for HIV infection.

Idaho was the last state in the union to report a case of acquired immunodeficiency syndrome (AIDS). Since that first case was reported on October 27, 1985, the reported cases of AIDS have grown steadily to a total of 523 cases as of June 30, 2002. An additional 539 cases of HIV infection have been reported in Idaho. According to the CDC's (Centers for Disease Control and Prevention) HIV/AIDS Surveillance Report of U. S. HIV and AIDS cases reported through December 2001, Idaho has the third lowest rate of AIDS cases in the country, at 1.4 per 100,000 population.

As of June 30, 2002, 373 persons in Idaho have died with complications from AIDS or HIV. There are 241 individuals living with AIDS in the state, and an additional 448 individuals living with HIV. The majority of the AIDS cases (44%) have been reported from District 4, which includes Ada, Elmore, Boise, and Valley County.

According to the 2002 Epidemiologic Profile of HIV/AIDS in Idaho, the epidemiological data has determined that there are three population groups at greatest risk of HIV infection in Idaho: men who have sex with other men (MSM's), women with high risk partners, and injection drug users (IDU's). HIV/AIDS in Idaho is primarily found in white males who have sex with other males. Though the percentage of cases involving males who have sex with males is decreasing slightly, this is still the most common risk factor. The risk category of injection drug use is increasing for both men and women. Heterosexual transmission, as the only identified risk, is also increasing for both males and females.

Since 1985, Idaho has averaged 30 reported AIDS diagnoses per year. In 1996, after the protease inhibitors became widely available, which seemed to extend life and delay progression from HIV to AIDS for many people, AIDS diagnoses have been on the decline nationwide through 1999. A similar trend is seen in Idaho from 1997 to present. The number of AIDS cases diagnosed in 1999, 2000, and 2001 (n=23, 20, and 17, respectively) are the lowest since 1989 and have declined over the last 3 years. National trends, however, show a leveling and slight increase from 1999-2000. This may be due in part to the continuing spread of HIV infections in the U. S. population resulting in a larger susceptible population for AIDS, insufficient medication compliance, and/or resistance to medications. As Idaho's AIDS trends have generally followed the nation's trends, it is possible that Idaho, too, will see an increase in AIDS cases over the next few years. HIV case reports have averaged 39.6 cases per year.

Over the past 10 years (1992-2001), men have been diagnosed consistently in higher numbers than women. Reported cases in women have remained relatively steady when compared to men, averaging 9.6 per year and not showing a decrease over time. Men average 49.4 cases diagnosed during the time period, but have shown an overall decrease in reported cases since 1992. As a result, over the time period, the proportion of women diagnosed has increased when compared to men.

During 1992-2002, the age group with the most report HIV/AIDS diagnoses are individuals aged 30-39 years. By exposure category, during the last 10 years, MSM has remained the highest reported mode of exposure, second is IDU, and the third highest reported mode of exposure is heterosexual. However, for the two most recent years, cases with mode of exposure not classified have been the second highest reported exposure category. The Idaho STD/AIDS Program expects this mode of exposure to decrease retrospectively after case investigations

and reclassifications due to those investigations take place.

The most affected racial/ethnic group during 1992-2001 has been whites. Hispanic/Latino ethnicity is the next most affected category, followed by African Americans and American Indians/Alaska Natives.

Idaho has one statewide HIV prevention community-planning group: the Idaho HIV Prevention Planning Group (IPPG). A membership committee is charged with annually reviewing the membership profile of the group and recruiting new members that reflect PIR (Parity, Inclusion, and Representation). New members are identified in the fall and membership begins in January with an orientation to the community planning process. Membership includes one member from each of the districts Regional Prevention Council (RPC) and representation from the three regional Ryan White HIV Care Consortia. The role of the RPC is to encourage and obtain local community input and involvement in the planning process, to assist in identifying met and unmet HIV prevention needs, provide recommendations to the IPPG on priority groups and interventions, and implement local HIV prevention strategies. Involving the Ryan White HIV Care Consortia allows for coordination among the Ryan White Title II and HIV prevention programs.

Changes for CY2003 will create a combined HIV prevention and care planning group. Recent changes within Health Resources Services Administration (HRSA) recommend Ryan White Title II grantees to institute a community planning process in order to receive HIV care funding for 2003. Since the Center for Disease Control and Prevention requires a similar prevention planning process, combining both care and prevention seems feasible. Four of the seven health district prevention advocates are also care case managers and the Ryan White Title II Program and HIV Prevention Program share the same Program Manager and are housed in the same bureau and program within the Idaho Department of Health and Welfare.

In CY2002 the Idaho Prevention Planning Group requested an ad hoc committee be formed with the following charges:

- Seek input and agreements from HIV/AIDS care representatives on the proposed combined planning group.
- Determine who should be at the table for the combined group.
- Make changes in the Idaho Prevention Planning Group (IPPG) bylaws as needed to reflect a combined group: purpose, role, membership, officers, governance of meetings, and committees.
- Define a new group structure to best accomplish its tasks: how

meetings will be structured, how committee will do their work, and how decisions will be made.

The IPPG voted to change its name to the Idaho Care and Prevention Council (ICPC). The ad hoc committee recommended the following committees: needs assessment, resource inventory, gap analysis, prevention intervention, care services, and administrative. An executive committee is made up of chairs of the preceding committees. The chairs of these committees along with the community co-chairs were provided a two-day leadership training in August 2002 to help build capacity for their leadership roles in committee working beginning in 2003.

The Ryan White Title II case management and the HIV prevention case management will be partnering to provide both care and prevention case management to HIV sero-positive individuals. Care case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. Care case management supports the importance that health care is a human right and access to care and support also contributes to the prevention of HIV infection. Prevention case management (PCM) is a combination of HIV risk-reduction and case management and provides intensive, individualized support and prevention counseling. The premise of PCM is helping high-risk persons address their most pressing medical and psychosocial needs through a supportive, case management relationship. Individuals living with HIV or AIDS utilizing PCM will then be able to prioritize and understand HIV prevention, and better able to remove themselves from high-risk situations or environments.

The Comprehensive HIV Prevention Plan includes prevention activities with the following target populations: men who have sex with other men (MSM), women with high risk partners, and injection drug users (IDU). Interventions developed for each of these targeted populations have been recommended by the ICPC.

Interventions targeting MSM's will work to build MSM's skills and abilities to practice safer sex behavior, reduce MSM's risk of contracting and/or transmitting HIV, will increase their knowledge levels about risk of sexual behaviors and receive increased peer support for behavior change, will have access to HIV counseling, testing, referral, and partner notification services, and MSM's will receive information and skills to reinforce safer sex norms and safer sex will become the mutually accepted norm for MSM's.

Interventions targeting women with high risk partners will work to increase women's awareness about their risk of HIV infection, increase women's awareness about their serostatus and risk of HIV infection, reinforce risk reduction behaviors, and provide access to HIV prevention and care services, increase women's knowledge of HIV prevention and transmission and improve skills in communicating with partners on safe sex, and reduce women's risk of HIV transmission through providing women the skills to build decision-making, communication and self-efficacy skills around safer sex behaviors.

Interventions targeting injection drug users (IDUs) will work to reinforce safer needle use and sexual practices among IDUs and increase IDUs knowledge of HIV prevention and transmission, increase IDUs awareness about their serostatus and risk of HIV infection, reinforce risk reduction behaviors, and provide access to HIV prevention and care services, increase awareness of IDUs risk of HIV transmission when sharing needles, and increase IDUs knowledge about the risk of needle use and sexual behaviors, peer support for behavior change, and tools to assist them in practicing safer behaviors.

Process for Development of Idaho's SCSN

The Idaho STD/AIDS Program developed the Statewide Coordinated Statement of Need (SCSN) by conducting statewide surveys of persons living with HIV and AIDS, district health staff, AIDS consortia members, AIDS advocates and HIV/AIDS care providers. Key informant interviews were also conducted with providers from district health departments, AIDS organizations, and clinic providers. In addition, the following existing data sources were reviewed:

- Idaho Comprehensive HIV Prevention Plan, 2001-2003, including Idaho's Epidemiological Profile
- HIV/AIDS Community Resource Inventories for each of Idaho's seven health districts
- Idaho's Title II AIDS Drug Assistance Program reports and statistics
- Idaho's Title II HIV/AIDS Care Consortia reports and statistics
- Idaho State Planning Grant: Idahoans Without Health Insurance (A data report)
- HIV/AIDS Surveillance Report: US HIV and AIDS case reported through December 2001, Year-end edition, Vol. 13, No. 2

Surveys

In August 2002, AIDS Advocates/Case Managers in each of Idaho's seven district health departments were asked to administer consumer and provider surveys to solicit individual and organizational viewpoints on HIV/AIDS care strengths, needs and priorities in their districts. The surveys were completed by the following groups:

Persons living with HIV/AIDS	96
HIV/AIDS care providers	12
Health District staff	11
AIDS consortia members	02
AIDS Advocates/Case Managers	03
Total Surveys	124

Major service gaps, challenges, and goals for HIV/AIDS care, as determined by the data sources and the survey responses are contained in the next two sections of the SCSN.

HIV/AIDS Care Issues in Idaho

This section will first present perspectives on the quality and accessibility of services currently provided, the service gaps identified, and lastly discuss barriers to service provision.

Quality and Accessibility of Services that are Provided

The response rate from participants regarding client satisfaction from the consumer's needs assessment was extremely low; therefore, no analysis was completed. The most accessible and utilized services were CD4 and viral load testing, case management for medical services, and HIV specialty care. SSI entitlements, Medicare/Medicaid services, dental care, and nutritional supplements were reported as the most difficult services to access. Participants were also asked to rank seven HIV related services in order of importance. Overwhelmingly ADAP, CD4, and HIV specialty care services were the top three choices.

Services offered by Care Providers Surveyed

Of the 23 provider surveys which were completed and returned, the 4 key informant interviews with AIDS Services Organizations, and one key informant interview with a clinic the following services were discussed. The most common services provided to individuals living with HIV were western medical care, case management, testing and counseling, dental care, family planning services, health education, and STD/HIV prevention.

Specific Service Gaps

Based on consumer and provider survey responses service gaps which were reported by individuals living with HIV or AIDS included: inability to access or qualify for Medicaid/Medicare, SSI (Supplemental Security Income), dental care, nutritional supplements, SSDI (Social Security Disability Income), access to clinical trials, food assistance program, emergency assistance, and the AIDS Drug Assistance Program.

Barriers to HIV/AIDS Service Delivery

Consumer and provider survey respondents were also asked to identify the greatest barriers to delivering and receiving HIV and AIDS care services and the following barriers were identified.

- 21% managing entitlement systems (SSI, SSD, Medicaid, and Medicare)

- 15% travel (distance/financial)
- 13% limited services available

HIV/AIDS Care Goals for Idaho

The overall goals for the improvement of HIV and AIDS care in Idaho need to be addressed first from a statewide perspective and secondly from a regional perspective.

Idaho receives funding from both Ryan White CARE Act Title II and Title III; therefore collaboration between both the STD/AIDS Program and the Ryan White Clinic would be beneficial for the provision of comprehensive care to individuals living with HIV or AIDS. Development of appropriate HIV/AIDS comprehensive care should serve to provide guidance on a logical sequence of events that may be used to prioritize actions and establish bridges for interventions of increasing complexity to be carried out at different levels of the health system. The following tasks are necessary to develop a system of comprehensive care:

- The definition of roles and functions within each of the elements of the HIV/AIDS care continuum
- Establishment of the appropriate services and mobilization of the necessary resources to perform these roles and functions
- Construction of bridges between each of the elements of the HIV/AIDS care continuum

If these prerequisites are in place, it would be possible to begin to meet the individual needs of individuals living with HIV and AIDS at any point in the evolution of the HIV infection by providing the most appropriate and timely responses and referrals to services.

According to the Building Blocks model, four interrelated elements are needed for a comprehensive care for HIV/AIDS service delivery.

- Clinical management: early and accurate diagnosis, including testing, rational treatment and follow-up care
- Nursing care: promotion of adequate hygiene practices and nutrition, palliative care, home care and education to care providers at home and family, promoting observance of universal precautions
- Counseling and emotional support: psychosocial and spiritual support, including stress and anxiety reduction, risk reduction planning and enabling coping, accepting HIV serostatus and disclosure to others, positive living and planning of the future for the family
- Social support: information, provision or referral to peer support, welfare services, spiritual support and legal advice

The development of an HIV/AIDS comprehensive care program in Idaho should also enhance primary prevention efforts, ensuring that people who are not infected do not get HIV, those who are already infected do not transmit HIV to others, and those who are already infected do not get re-infected.

By developing a comprehensive care program and utilizing the resources available many of the barriers and gaps which were identified may be eliminated or reduced. However, the issue of individuals living with HIV or AIDS accessing or qualifying for SSI, SSD, Medicare/Medicaid will continue to be a challenge as the eligibility to these programs is not determined by the Ryan White Program or providers. By utilizing case managers to work collaboratively with physicians, dentists, and other healthcare providers an integrated continuum of care could be established. The STD/AIDS Program will work collaboratively with the ICPC to ensure the development of a HIV/AIDS comprehensive care program.